

5 Language Barriers as a Social Phenomenon

Distinctive Impacts on Health Communication in Japan and the United States

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Papina, from the Philippines, was involved in a car accident soon after she came to Japan. Her Japanese proficiency at the time was near-novice, limiting her to brief greetings. The other driver fled. No one was around to call for an ambulance or the police. Experiencing great pain and shock, Papina drove to a hospital nearby for emergency treatment. To her surprise, she was turned away. She was told to come back the next day. Papina believed that she was sent back home because she did not come in with an ambulance.

Cherri, from China, is a doctoral student at a Japanese university. Cherri writes research manuscripts and presents conference papers in Japanese. When she got a fever, she went to a hospital to obtain antibiotics. Cherri's doctor prescribed painkillers instead. Although Cherri had language proficiency in communicating her perspectives and needs, she decided not to say anything because she didn't know how to express her disagreement politely without offending her doctor. Instead, Cherri visited another hospital, hoping the physician would offer her preferred medication.

Language barriers faced by immigrants and refugees have been widely recognized as a social determinant of health. Nevertheless, the literature has predominately focused on the impacts of language barriers on provider-patient interactions. Papina's and Cherri's cases demonstrate that language barriers can influence patients' health and health communication in all stages of care (Terui, 2017). This chapter examines how individuals' experiences of language barriers are constructed and limited by their host society's sociopolitical and sociocultural contexts. Our conceptualization of language barriers extends the Model of Bilingual Health Communication (Hsieh, 2016) and echoes with culture-centered approach (Dutta, 2008) and Integral Fusion (Hsieh & Kramer, 2021).

Reconceptualizing Language Barriers as Localized, Situated Experiences

In the *Model of Bilingual Health Communication*, Hsieh (2016) conceptualized bilingual healthcare as a socially constructed, goal-driven communicative activity that requires multi-party coordination on the meanings and processes of healthcare delivery. In addition, language-discordant patients' experiences are situated in the larger society, shaped by the corresponding normative expectations of the sociocultural and sociopolitical environments (Hsieh, 2018). As such, system-level influences can impact all aspects of care, resulting in diverging experiences, meanings, and outcomes. To truly appreciate language barriers, Hsieh (2016) urged researchers to “examine the impacts of these system-level influences in enhancing/compromising quality care” and “explore the system-level structures that best promote successful bilingual health care” (p. 274). In this chapter, we aim to explore the various system-level influences that shape language-discordant individuals' experiences of health and illness in Japan and the United States.

Our approach to our participants' experiences is grounded in culture-centered approaches (Dutta, 2008). A *culture-centered approach* invites marginalized communities to engage in dialogues that challenge existing social structure/order, address historically situated social injustice, and collaborate and co-create structures and knowledge with the larger society (Dutta, 2018). Dutta (2007) conceptualized culture as “a complex and dynamic web of meanings that is continuously in flux, as it interacts with the structural processes that surround the culture” (pp. 310–311). Dutta's focus on the structural processes echoes with our interests to examine “the organization of social systems, the patterns of distribution of resources, and the patterns of control of these resources that are inherent in the production and reinforcement of social inequities” (p. 319). In addition, because a culture-centered approach recognizes the potential bias of the larger society and legitimizes the perspectives of the marginalized, such an approach is particularly valuable to examine how language-discordant individuals experience disparities and alienation.

Finally, *Integral Fusion*, a type of cultural consciousness proposed by Hsieh and Kramer (2021), guides our understanding and analysis of our participants' experiences. Integral Fusion is a result of intercultural interactions. As individuals travel between and across different cultures, they develop cultural perspectives that enrich their understanding of their realities. In addition, their experiences are situated in the larger society, resulting in pan-evolutionary effects that change both the cultural sojourners and the host society (Hsieh & Kramer, 2021). In a pluralistic society, its cultural members constantly and continuously engage in dynamic interactions, through which individuals

negotiate, resist, and collaborate to reach mutually agreeable solutions (Terui & Hsieh, 2020). Cultural members' interactions are influenced by and actively shape the evolving, shifting political, economic, and dialogic forces within the larger society. In short, we view culture as a living process through which cultural participants and their host society continuously shape and are shaped by each other's presence and experiences.

The voice of marginalized populations, situated in their cultural perspectives and contexts, provides invaluable insight into how they construct meanings in health and illness, understand health behaviors, and identify possible solutions. By examining immigrants' and refugees' experiences of language barriers as localized, situated experiences, we aim to explore how such experiences can be shaped and constrained by the host society's larger sociopolitical and sociocultural contexts.

Language Barriers as a Social Phenomenon

The literature on language barriers has provided opportunities to address health disparities experienced by immigrants and refugees. Within the literature, an overwhelming number of studies centered on provider-patient interactions. Few studies have theorized language barriers in health contexts. A lack of theoretical framework reflects a common misconception – assuming language barriers are practical, technical problems in healthcare settings, rather than communicative challenges involving the intersections of medicine, culture, language, and one's lived environments.

For example, in Segalowitz and Kehayia's (2011) extensive review of language barriers in healthcare, language barriers are defined as “language-based obstacles to successful communication *between a patient and a health care provider* that have *consequences* for health care delivery” (emphasis added; p. 482). They emphasized the importance of examining language barriers in healthcare because of “its *universality* and the very high stakes that may be involved in miscommunication” (emphasis added; p. 486). We agree that language barriers in healthcare have high stakes. Their definition and conceptualization, however, failed to capture the complex, multidimensional, and nuanced nature of language barriers in healthcare in three ways.

First, it is important that we expand the investigation of language barriers in health contexts beyond provider-patient interactions. Although language barriers may be most salient and observable in medical encounters, they also impact individuals' access to care and health maintenance in everyday life (e.g., obtaining health information, navigating healthcare systems, and maintaining treatment adherence; Terui, 2017). By looking beyond medical encounters, researchers can identify a wide range of intervention points and solutions that address

the impacts of language barriers on the access to, process of, and outcomes of care.

Second, individuals' experiences of language barriers vary in intensity and are often shaped by their levels of language proficiency and sociolinguistic skill. By focusing their investigation of language barriers during medical encounters, researchers inadvertently limited their attention to the negative consequences of clinical care (Suarez et al., 2021). However, the impacts of language barriers are not limited to clinical consequences. For example, language barriers may be intentional discrimination and/or structural barrier utilized by a host society that aims to alienate cultural Others. Recognizing such hostile attitudes, immigrants and refugees may avoid preventive care, delay help-seeking behaviors, and rely on interpersonal networks for illness management (Hsieh & Kramer, 2021).

In addition, the presence of language barriers should not be conceptualized as a dichotomous, either/or phenomenon limited to "foreigners." For example, a host society or health facility may provide language access (e.g., interpreters and translated materials) for certain groups of language-discordant patients (e.g., deaf patients using American Sign Language), but not others (e.g., Spanish-speaking migrant workers). English-speaking foreign patients in Taiwan may be less likely to experience language barriers than local elderlies who speak only Taiwanese because all physicians learn medicine through English textbooks and use English for patient record-keeping, but not all physicians can speak Taiwanese (i.e., Mandarin is the official language in Taiwan; Hsieh, 2018).

Finally, solutions to language barriers cannot be one-size-fits-all. Segalowitz and Kehayia's (2011) assumed that language barriers in healthcare can be addressed through universal solutions. While language-discordant individuals may share universal experiences, they also face unique challenges and barriers due to cultural particulars within a host society. Different host societies often entail distinct sociocultural and sociopolitical environments. These environments and their cultural particulars hold diverging forces in shaping (a) the meanings of health and illness, (b) the normative expectations of healthcare behaviors, and (c) the social resources that are available to cultural Others (e.g., immigrants and refugees).

Hsieh (2018) argued that (a) language discordance is a social phenomenon that may entail diverging meanings and experiences in different countries, (b) language-discordant patients may not share similar experiences even if they are in the same country, and (c) disparities in language concordance may be confounded with other disparities and cultural particulars that are unique to a host society. For example, in the United States, language-discordant care generally means that the patient has limited English proficiency (rather than the provider is using his second language); in contrast, in Japan, language-discordant care

may mean that both patients and their physicians communicate in their second language (e.g., English; Terui, 2017). In addition, depending on the patients' ethnicity and/or country of origin, language-discordant patients may experience preferential treatment (e.g., an English-speaking, white patient from France) or potential discrimination (e.g., a Bantu-speaking, black patient from Zimbabwe) in a host society even though both would be considered to receive language-discordant care (Hsieh, 2018; Terui, 2017). In short, it is important to recognize that language barriers in health contexts are more multidimensional than the literature depicted.

In summary, we argue that language barriers are complex, multidimensional, and nuanced social phenomena. Individuals' experiences of language barriers are influenced by the culture, policies, and lived environments in the corresponding host society.

Health Policies and Access to Care for Immigrants and Refugees

How immigrants and refugees experience their health and language barriers in healthcare largely depends on the culture of the host society, its approaches to healthcare, and the availability of social resources (Hsieh, 2018). To further delineate host societies and local authorities' willingness to make accommodations for immigrants and refugees, we will first examine policies related to language access in healthcare in Japan and in the United States. Our analysis centered on social policies and legal regulations related to providing culturally and linguistically appropriate care in these two countries.

Health Policies and Language Access in Japan

Under the Japanese social security system, immigrants and refugees with valid documentation who stay in Japan more than 90 days are eligible to have national health insurance (国民健康保険 Kokumin kenko hoken; Okubo, 2004). This national health insurance provides equal quality of medical treatment and access to healthcare to every insurance holder. However, when it comes to social resources, specifically language services, the Japanese state of being a *jus sanguinis*¹ reinforces the tendency to exclude immigrants and refugees without Japanese blood (Sato, 2009). The Japanese government sets no legislative guidelines for providing language services to immigrants and refugees, except for Japanese returnees from China (Iida, 2010). Those with Japanese blood are entitled to receive government support to have access to healthcare interpreters (Iida, 2010, 2011). Immigrants and refugees without Japanese blood primarily rely on services provided by local governments, non-profit organizations, and medical institutions (e.g.,

multilingual websites, volunteer interpreters, and accessibility technologies; Nakamura, 2012).

Health Policies and Language Access in the United States

Unlike Japan, immigrants' and refugees' children are US citizens as long as they were born in the United States and its territories. The US government offers Medicaid and Medicare for US citizens and permanent residents who meet specific qualifications. Medicare is a government health insurance program available for ones who (a) are 65 or older, (b) are younger than age 65 with specific types of disabilities and/or are with end-stage renal disease (Centers for Medicare & Medicaid Services, 2021a). Medicaid is a needs-based program funded by both federal and state governments. One must meet income-based eligibility to receive the service (Centers for Medicare & Medicaid Services, 2021b). Individuals who do not meet these criteria select their own health providers based on quality and cost either by themselves or through employer-based health programs (De Gagne et al., 2014). Choosing health insurance can present additional obstacles to maintaining good health for immigrant populations who are not familiar with the US social and healthcare systems (De Gagne et al., 2014).

With the continual increases not only in the number of immigrants and refugees, but also in the diversity of these groups, the Office of Minority Health at the U.S. Department of Health and Human Services published the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). The CLAS Standards require healthcare institutions receiving government funding to provide linguistically and culturally appropriate healthcare (Barksdale et al., 2017). Unfortunately, such a policy does not ensure successful mitigation of adverse effects caused by language barriers because not all medical providers are knowledgeable about laws and policies and how to implement them in their institutions (Barksdale et al., 2017). In fact, several studies suggest that legislation and policies have limited impacts on healthcare providers' use of language-related services (Ginde et al., 2010).

Method

Data used in this chapter were collected by the first author through semi-structured, in-depth interviews with language-discordant immigrants and refugees living in Japan (N = 30) and the United States (N = 30). Participants recruited in Japan are from 13 countries, and the participants recruited in the United States are from ten countries. Both English and Japanese languages were used for data collection. More than 50 hours of interview data were transcribed verbatim.

The data gathered using Japanese was first analyzed in Japanese before translating them into English. This procedure allowed us to preserve the cultural contexts, ensuring minimal distortions and lost meanings in the translation processes (Squires, 2009). Using narrative approach (Fisher, 1987), we explored the ways these participants understand their experiences of facing language barriers in managing health. We identified major issues salient to our language-discordant participants through applied thematic analysis (Guest et al., 2011), highlighting their experiences in accessing healthcare and related processes and the sociopolitical and sociocultural elements of their lived environments.

Challenges and Recommendations

Revisiting Papina's Case

Language barriers compromise patients' familiarities and accessibilities with the healthcare systems in their local communities. Many participants shared their concerns about their language and interpersonal skills in communicating with medical providers. Such concerns can arise from lack of proficiency and uncertainties about sociocultural norms. However, they also noted that these concerns do not always prevent them from seeking medical treatments because they know the locations of the hospitals and clinics and because they believe that they can receive treatment as long as they get to a healthcare facility. Such attitudes are shared by immigrants and refugees in both Japan and the United States.

However, when it comes to an emergency, unexpected waiting time could be troublesome and life-threatening, and knowing the locations of healthcare facilities is not adequate to promptly utilize resources in Japan. Immigrants and refugees in Japan experienced language barriers in accessing emergency care, particularly with the ways to use ambulances. Papina explained,

After I came to Japan, I had a car accident. I drove to the hospital by myself. There is no one who could call 119 and the police for me. The other driver fled, and I was alone... [When I arrived at the hospital,] they said, "Not today. Come back tomorrow morning. Not tonight. You are okay today." They said it's because I didn't come in an ambulance.

Papina did not feel confident to call 119, a local telephone number for emergency and an equivalent to 911 in the United States. Thus, she drove to the hospital by herself, believing that she would be able to see a doctor once she got there. Many participants said that they would have made the same decision as Papina, visiting an emergency care unit by themselves without using an ambulance. Remembering the time when she

accompanied a friend to a hospital in an ambulance, Ida explained, “I was surprised. The Japanese ambulance came so quickly! In my country [Indonesia], it’s faster to go to hospitals by ourselves compared to calling an ambulance. And we’d have to pay for it.”

Calling an ambulance requires individuals to articulate the specific nature and the exact location of the emergency, which may demand the kind of linguistic skills (e.g., proficiency, accuracy, and clarity) that language-discordant individuals may not have – particularly in an emergency situation that involves heightened emotions and compromised cognitive abilities. This problem is reduced when the incident happens at or near the place they live. Individuals typically know their address and can articulate it without much difficulty. However, when the need for an ambulance occurs outside the individual’s familiar areas (e.g., the cases of traffic accidents), it is difficult to identify the exact location. This problem is exacerbated in Japan because only major Japanese highways have names – neighborhood streets do not. Articulating the specific location takes more time and is more nuanced. Thus, language-discordant individuals must possess a higher level of communicative skills to convey their situations and needs. They also face a higher risk of delayed care (e.g., ambulance misdirected to the wrong place) as a result of miscommunication. Together, such concerns can reduce a person’s self-efficacy in seeking emergency care through paramedics.

Revisiting Cherri’s Case

Language-discordant individuals learn appropriate and desirable behaviors in their host societies through daily interactions and observations. Having learned what could be perceived as culturally appropriate ways, these cultural sojourners work to perform these identities in medical encounters, aiming for desirable identities, relationships, and health outcomes. Nevertheless, they face unique challenges that prevent them from asserting desirable identities due to language barriers.

Many immigrants and refugees in Japan are aware that Japanese society places high value on politeness, including the belief that politeness and agreeableness are key components to successful interaction (Lebra, 2004). In provider-patient interactions, politeness and agreeableness play more important roles, especially in light of the power differences present in provider-patient dyads. Medical providers have more power based on the amount of information they hold about medical treatment and their high social status in Japan. When disagreements occur in provider-patient interactions, patients face difficulties in communicating their thoughts and preferences in an effective manner. Cherri shared her narrative.

When I was in China, I used Kampo (漢方: Chinese traditional medicine). I have a pretty good idea of which part of my body suffers and what I need to heal. I went to a hospital when I got a fever. Although I thought I needed a particular medicine to draw out the irritation, I was prescribed a painkiller. I couldn't point it out. Isn't it awkward if I explain to the doctor how the human body works? I would say things if it were in China. The Chinese doctor would understand what I am saying without that much effort. Japanese is less direct than Chinese. I try not to say a lot because I don't know the better ways to communicate my concerns... in the Japanese way.

Cherri was in a bind. She recognized that she did not have the linguistic and interpersonal skills needed to discuss her preferred treatment without implying that she is more knowledgeable about Kampo and other medicine than her doctor, a serious face threat to physicians in Japanese culture. As a result, she decided to forego her agenda and visited a different clinic hoping that the next provider would offer her what she wanted.

Other participants recruited in Japan shared similar experiences. During the interviews, the first author found that they have high language proficiency in Japanese, allowing them to communicate their concerns in detail. However, their language proficiency is not high enough to communicate nuanced meanings without being direct or blunt. If they have had language skills similar to those of native Japanese speakers, they would have been better able to express their concerns without offending medical providers. Daily interactions taught them that culturally inappropriate interactions may contribute to social sanctions (e.g., less friendly interactions). They decided not to speak up about their concerns or disagreements to avoid potentially negative consequences (e.g., unfavorable treatment). In short, language-discordant patients in Japan may face prolonged time to receive treatment and increased financial burdens due to the sociocultural and sociopolitical contexts.

Universalities and Cultural Particulars of System-Level Forces

The narratives collected in Japan and the United States show both cross-environmental and environment-specific influences on language barriers. Participants in both countries indicated an awareness of the impacts of their language barriers both inside and outside provider-patient interaction. Charmaz (1991) described that individuals' experiences of chronic illness are not static but often fluctuate between high and low points as they adapt to illness conditions and manage activities

in everyday life. Our participants' experiences with language barriers echo with such an understanding. When they feel ill, their language proficiency decreases due to their reduced cognitive abilities for everyday tasks. Participants recruited in Japan and the United States both mentioned that when they are sick, their interlocutors (e.g., friends and physicians) can face greater language barriers when communicating with them. For our participants in Japan and the United States, their experiences with the oscillating struggles with language barriers and the perceived burdens placed on social interactions with native-speaking others are fundamentally similar. From this perspective, the sociocultural and sociopolitical environments do not significantly influence language barriers, affirming the concept of universality in language barriers depicted in Segalowitz and Kehayia (2011). Nonetheless, such a concept is not applicable in a number of situations.

As demonstrated in Papina's case, some narratives shared by participants recruited in Japan highlighted that the lack of knowledge about local procedures accentuates the adverse influences of language barriers, posing a critical challenge to accessing healthcare, especially in an emergency. Similar to the notion that language-discordant patients tend to be unaware of environment-specific diseases, attributed by some to a lack of social interaction with local individuals (Ndiaye et al., 2011), language barriers tend to require additional effort to learn local procedures needed to utilize resources (Wakimoto et al., 2013). Frequently, language-discordant patients do not recognize the need for such information until encountering problematic situations or outcomes (e.g., an emergency; Wakimoto et al., 2013).

Participants in both countries shared the experiences of obtaining information and perceptions about healthcare through their social networks. Participants indicated that interpersonal interaction and interpersonal relationship management largely affect access to healthcare. In particular, language barriers (a) contribute to developing distorted knowledge and (mis)understandings of healthcare in the host society, and (b) impose additional obstacles in managing interpersonal relationships within an individual's limited social network. The predominant difference in the impact of these distortions and misunderstandings of healthcare systems in the United States and Japan is whether or not these language-discordant individuals can dispel distortion and misunderstandings by obtaining firsthand experiences through using the healthcare system in their host societies. Relatively manageable healthcare cost in Japan presents fewer obstacles to obtaining firsthand experiences than healthcare costs in the United States. Having the correct information about the local healthcare system is critical for gaining timely and effective access to healthcare.

The accessibility to healthcare interpreters in the local environments also influences language-discordant patients' access to healthcare. Lukes and Miller (2002) noted that immigrant and refugee populations tend to

view a lack of visible symptoms or noticeable discomfort as less crucial in seeking healthcare, thereby placing little weight on preventive care. Some of our language-discordant participants indicated that symptoms are not critical enough to place burdens on other people. As a result, they prioritized harmony in interpersonal relationships and/or avoided trouble or inconvenience to others. Such concerns may be particularly heightened for immigrants and refugees as they are motivated to conserve resources within their limited support networks in case of future needs. Most of the participants recruited in Japan did not have easy access to healthcare interpreters, and they typically bring their family members and friends as an interpreter. Even when language-discordant patients want to visit hospitals/clinics, these participants in Japan sometimes have to wait for their friends' or family members' availability to schedule an appointment for medical treatment. Relationship and identity management can be costly, particularly when individuals have close and limited social networks, as is often the case with immigrants and refugees in general and recent immigrants in particular.

Our findings also support previous studies which demonstrated that language barriers produce less effective provider-patient communication due in large part to the patients' lack of linguistic abilities in expressing their concerns, symptoms, and preferences for treatment, as well as their proficiency in understanding the information given by their medical providers (Flores, 2006). We argue that such difficulties in provider-patient interaction do not always reflect language-discordant patients' lack of language proficiencies. Individuals with high levels of language proficiency still encounter substantial miscommunication in sharing information that is less accurate than it may appear. Some participants recruited in both countries reported that they *think* they know how to express their symptoms, but they also wonder whether or not the words they use are accurate. These participants noted that there are many words and expressions they heard in daily conversations, and they used these words and expressions in the interactions with their providers, believing that they knew the meanings. However, they later wondered how accurately they explained their perspectives and symptoms. When medical providers observe language-discordant patients speaking fluently and their explanations make sense to the medical providers, the medical providers may not recognize possible misunderstandings (Hsieh, 2016). Being able to say specific words, even with excellent pronunciation, does not always mean that individuals understand the nuanced meanings the words carry (Maddux, 2002). To express a person's symptoms and provide information about how one feels in culturally appropriate and understandable ways, individuals must be able to do more than just naming the symptoms (Holland & Quinn, 1987).

Similarly, having a high degree of language proficiency does not always lead to better care. When healthcare providers perceive their

patients have a high degree of language proficiency, they may formulate inaccurate assumptions about the patients. Some participants recruited in the United States shared that local individuals in the United States may not recognize language-discordant patients' lack of familiarity with local norms. Healthcare providers often overestimated patients' knowledge and understanding of procedures and treatment due to their high level of language proficiency. Participants who have lived in multicultural, multilingual communities (e.g., Miami and New York City) often raised such concerns. In other words, large, multilingual, and multicultural communities may hold differing expectations and assumptions for language-discordant patients when compared to smaller, less diverse communities. This particular challenge is mentioned only by participants recruited in the United States, underscoring the notion that each environment, even within the same country, contributes to differing influences of language barriers on experiences of health management, as well as the quality of provider-patient interaction.

Furthermore, the Japanese environment provides unique advantages and challenges for language-discordant individuals whose native language is English. A few participants recruited in Japan were native speakers of English. Their narratives reflect the influences of language hegemony and language hierarchy. Their narratives illustrate that, to a certain degree, language-discordant patients expect their medical providers to be able to communicate in English. Such an expectation was not shared among other participants in Japan nor those recruited in the United States: None of them blamed the medical providers' language skills in patients' native language (i.e., Chinese and Spanish, etc.) as being the cause of miscommunication. Such a hegemonic power of the English language creates unique interactional dynamics in provider-patient dyads.

Finally, narratives support the idea that language barriers do not always function negatively in healthcare settings. Previous literature has depicted language barriers as obstacles in provider-patient communication (Street, 1992). However, we argue that language barriers do not always provoke weak and inferior patient roles. Individuals with language barriers sometimes strategically use their non-native status as a resource useful in meeting healthcare goals (Terui, 2012). For example, when teased about his uncertainties/anxieties (and needs for social support), the participant in the United States embraced the powerless identity. It allowed him to play an active and engaged patient role without worrying too much about being seen as annoying. By reframing the nature of language barriers, it is possible for patients to be more comfortable when engaged in language-discordant provider-patient interactions. As strategic actors, individuals actively negotiate and shape contexts to further their goals (Goodwin & Duranti, 1992). As they co-evolve with the deep cultural and social norms and contexts in host societies, language-discordant individuals also actively and strategically

re-arrange and negotiate their tasks, identities, and relationships within the immediate, interactional, localized contexts.

In conclusion, language proficiency alone does not overcome the adverse effects of language barriers. Language-discordant patients understand their language barriers in the context of their surrounding sociocultural and sociopolitical environments. The sociocultural and sociopolitical environments place both shared and unique challenges for language-discordant patients to navigate their management of health and illness. It is necessary to consider the fluctuating, multidimensional nature of language barriers when developing interventions to deepen understanding and ultimately to improve health among language-discordant patients.

Note

- 1 Jus sanguinis is a principle of nationality law by which citizenship is determined or acquired by the nationality or ethnicity of one or both parents.

Recommended Readings

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